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In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD, PETITIONERS

v.

EDWIN G. HYDE, RESPONDENT

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTION PRESENTED

Whether an arrangement by which a hospital secures the full-time, exclusive services of anesthesiologists to attend its patients is unlawful per se under the Sherman Act because it "ties" the patient's use of the hospital's operating room to the use of the hospital's anesthesiologists.

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OPINIONS BELOW

The opinion of the court of appeals (App. A, *infra*, 1a-19a) is reported at 686 F.2d 286. The opinion of the district court (App. B, *infra*, 20a-47a) is reported at 513 F. Supp. 532.

JURISDICTION

The judgment of the court of appeals (App. C, *infra*, 48a) was entered on September 20, 1982. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976), provides in relevant part: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations, is declared to be illegal."

STATEMENT

1. East Jefferson General Hospital is a large public hospital in the New Orleans metropolitan area.[1] At its opening in 1970 the Hospital concluded that anesthesia services would be best provided if the Hospital had the full-time services of one or more anesthesiologists. It accordingly invited anesthesiologists to make proposals for a contract to provide these services.

After some negotiations, which included discussions with respondent (who had moved from practice in Florida to practice at a hospital in metropolitan New Orleans), the Hospital entered into a contract with Roux & Associates ("Roux"), a professional medical corporation. The contract was "exclusive": Roux promised that its anesthesiologists would not work elsewhere, and the Hospital agreed not to engage other anesthesiologists during its term. The term of the contract was one year, renewable for additional yearly periods unless either the Hospital or Roux should give 90 days' notice.

The Hospital was well satisfied with the services of the Roux anesthesiologists, and it allowed the contract to be renewed automatically until 1975, when it again

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[1] The Hospital is governed by petitioner Board of Directors, twelve people selected by petitioner Jefferson Parish Hospital District No. 2. The District is a political subdivision of the State of Louisiana. The Hospital was constructed with public funds in 1969. Day to day administrative decisions for the Hospital are made by an executive director selected by the governing body of the District. For convenience we refer to the two petitioners, the Hospital, and its executive director as "the Hospital."

The Hospital generally operates as a business, and petitioners have not argued that their decisions are protected by the state action doctrine of *Parker* v. *Brown*, 317 U.S. 341 (1943). See *Community Communications Co.* v. *City of Boulder*, 455 U.S. 40 (1982).

reviewed the arrangement. It considered other options and proposals and once more selected Roux to provide services.

The contract signed in 1976 ran for five years. Like the 1971 contract, it called for Roux to supply all of the necessary anesthesiology services at the Hospital. Although it was not labeled "exclusive," it provided that Roux would supply all anesthesiology services required for the care of the Hospital's patients (App. A, *infra*, 2a n.1; App. B at 23a). Like the 1971 contract, this one also called for Roux to supervise the anesthesia department and the nurse anesthetists who performed many of the routine procedures, and schedule the procedures. It gave Roux the ability to hire and fire the nurse anesthetists who would be employed by the Hospital. It gave the Hospital complete discretion to establish the charges to patients for anesthesia, requiring only consultation with Roux. The fees of Roux were set at 46% of the total billings of the anesthesiology department; the remainder of the billings pay the nurses' salaries and compensate the Hospital for space, equipment, and supplies. Roux thus was compensated whether its anesthesiologists performed the services or supervised their performance by nurse anesthetists.

Respondent applied in 1977 for a position on the Hospital's medical staff. The Credentials Committee of the staff approved his credentials, but the Board of Directors declined to admit respondent to the staff. It based this decision on the ground that the contract with Roux called for its anesthesiologists to supply all of the needed services (App. B, *infra*, 25a-26a). Respondent then filed this suit under the Sherman Act, contending that the contract with Roux was unlawful because it "tied" patients' use of the Hospital's operating rooms to

their use of Roux's services.[2] Respondent sought an injunction admitting him to practice in the Hospital, but he did not seek damages.

2. The district court entered judgment for petitioners after a bench trial (App. B, *infra*). It assumed without discussion that the contract establishes a tie-in and applied the Rule of Reason to the contract because, it concluded, the Hospital has no significant market power.[3] It then held the contract lawful because it produces significant competitive benefits and no countervailing anticompetitive effects.

With respect to market power the district court made a factual finding that the Hospital does not have "any advantages over any other hospitals in the area" (App. B, *infra*, 34a) and is in no "position to charge patients higher prices or to impose burdensome terms which could not be extracted in a completely competitive market" (*ibid.*). It based this latter conclusion on findings that the Hospital competes for patients in the New Orleans metropolitan area (*id.* at 33a). The court observed that patients choose hospitals throughout the

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[2] Respondent also argued that the denial of his application for staff privileges violated the Fourteenth Amendment's due process clause (both substantively and procedurally) and two Louisiana statutes. The district court rejected all of these contentions (App. B, *infra*, 42a-47a). The court of appeals did not reach them in light of its antitrust holding (App. A, *infra*, 5a n.3), and they are therefore not before this Court.

[3] The district court also concluded that the Rule of Reason should be applied because of the special circumstances of the medical profession (App. B, *infra*, 39a-41a). The court of appeals rejected this conclusion (App. A, *infra*, 14a-18a) in light of *Arizona v. Maricopa County Medical Society*, 102 S. Ct. 2466 (1982), and we do not present this aspect of the Fifth Circuit's decision for review by this Court.

area and that only 30% of those who live in East Jefferson Parish obtain hospital care at the Hospital (*id.* at 33a, 38a-39a). The court acknowledged that 70% of the Hospital's patients come from its neighborhood (*id.* at 39a) but reasoned that this does not show market power.

With respect to the benefits of the contract, the district court concluded that the arrangement ensured 24-hour service, "aids in the control and standardization of procedures and the efficient and less costly operation of the department[,] lends flexibility to the scheduling of operations [,] . . . permits the physicians, nurses and other technicians in the department to develop a work routine and a proficiency with the equipment they use in patient treatment; and it increases the Board's ability to monitor the medical standards exercised because there are fewer individuals involved" (App. B, *infra*, 32a-33a). Moreover, the court explained, the contract did not suppress competition but rather created more competition: "A closed department may enhance competition among the hospitals in the market by increasing the quality of medical care available. It may also serve to benefit competition among anesthesiology groups if the terms of the exclusive contracts are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals" (*id.* at 34a). It therefore entered judgment for petitioners.

3. The court of appeals reversed. It first held that the contract is a tie-in because patients in the "hospital's operating room (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain separately" (App. A, *infra*, 5a-6a).

It next held that the Hospital possesses market power as a matter of law because of "market imperfections in the health care industry" (App. A, *infra*, 9a). Although the Fifth Circuit did not find any of the district court's conclusions clearly erroneous, it pointed to the prevalence of third-party payments that reduce the incentives of patients to shop for low prices and the lack of complete information about the services they are buying; it also asserted that "patients tend to choose hospitals by location rather than price or quality" (*ibid.*). As a result, the court of appeals held, the geographic market is smaller than metropolitan New Orleans, the Hospital's market share is larger than the district court thought, and the Hospital thus has "sufficient market power in the tying product to coerce purchase of the tied product" (*id.* at 10a).

The court of appeals did not hold that the contract elevated prices of either anesthesia services or the package of operating rooms and anesthesia (App. A, *infra*, 11a-12a). The court concluded, however, that constant or declining prices coupled with the lower costs of service made possible by the contract just led to profits for the Hospital, which demonstrated the vice of the contract (*ibid.*).

Finally, the court of appeals turned to the consequences of the contract. It held that the benefits found by the district court could not be used to sustain the contract because the Hospital had not established that a closed anesthesia department is the least restrictive alternative for the creation of these benefits (App. A, *infra*, 13a). Moreover, the court expressed doubts about the existence of these benefits. One finding, concerning the contract's utility in guaranteeing 24-hour service, was held clearly erroneous (*id.* at 3a-4a & n.2, 11a n.7); others, such as the findings concerning competition

among anesthesiologists for the contract, were put to one side (*id.* at 12a n.9); still others, such as the findings concerning the supervision by Roux of the nurse anesthetists and the Hospital's supervision of Roux, were simply not mentioned.[4]

REASONS FOR GRANTING THE PETITION

1. The holding of the court of appeals sweeps aside as unlawful per se the "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians" (App. B, *infra*, 32a). See also *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F. 2d 1346, 1351 (7th Cir. 1982) (similar arrangements are "widespread" and have "been adopted by most hospitals in the Chicago area").

Hospitals routinely put together services, including space, equipment, drugs, blood, nurses, food, and some medical specialties such as anesthesiology, radiology, and pathology, that are delivered to patients as a package of medical care. These medical specialties and other inputs have in common the fact that they are needed for many hospital procedures, so that a full-time hospital-based staff is advantageous; at the same time, patients rarely know the identity of these specialists, so that a hospital's provision of these services by its own staff does not affect the degree of choice the patient possesses over his own care.

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[4] The court of appeals stated, for example, that the contract "reduces the incentive for improving or initiating techniques or procedures. Quality is lowered" (App. A, *infra*, 12a). The court did not mention, let alone hold clearly erroneous, the district court's contrary finding of fact. (It did hold erroneous, *id.* at 11a n.7, any finding that "strictly quality considerations" account for the arrangement.)

Until now every federal court that has considered an antitrust attack on such assembly of medical services had upheld the hospital. E.g., *Dos Santos, supra* (adopting the reasoning of the *district* court in this case and rejecting an argument that exclusive medical contracts amount to a boycott or other per se violation); *Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976) (an antitrust challenge to an exclusive medical contract is so "frivolous" that the suit must be dismissed for want of federal jurisdiction); *Capili* v. *Shott*, 620 F.2d 438 (4th Cir. 1980) (exclusive arrangement is reasonable and challenge also fails to show effect on interstate commerce); *Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-415 (rejecting after trial a large number of different antitrust claims). Every state court that has encountered similar claims under state antitrust law also has sustained the hospitals' practices.[5]

The Fifth Circuit's decision thus creates a conflict. Practices that are unlawful per se in Louisiana, Texas and Mississippi are lawful and prevalent everywhere else.

The court's reasoning, moreover, is difficult to cabin. The court has depicted the Hospital as a sort of bazaar in which physicians hawk their wares to assorted

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[5] *Rumple* v. *Bloomington Hospital*, 422 N.E.2d 1309 (Ind. App. 1981); *Centeno* v. *Roseville Community Hospital*, 167 Cal. Rptr. 183 (Cal. App. 1979); *Dattilo* v. *Tucson General Hospital*, 23 Ariz. App. 392, 533 P.2d 700 (1975); *Letsch* v. *Northern San Diego County Hospital District*, 55 Cal. Rptr. 118 (Cal. App. 1966); *Blank* v. *Palo Alto-Stanford Hospital Center*, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).

bystanders. Because anesthesia *can* be sold separately from surgery and blood in such a marketplace, it *must* be sold separately.

On this reasoning, however, every product is a tie-in to the extent it contains potentially-severable elements. Every hospital supplies nurses and food rather than allowing patients to bring (or designate) their own favorites.[6] Most hospitals supply radiology, pathology, and anesthesiology; many hospitals supply cardiology and other specialties too.

Under the court's approach such "tie-ins" are unlawful per se because every hospital has market power as a matter of law. The court inferred market power from "imperfections" that are generic to the health care industry and from the fact that many patients use hospitals located near them. Every time a hospital furnishes a "tied" package, then, it commits a crime.

Any group practice of medicine also is unlawful per se, because each involves a package sale and the same generic market power. The Group Health Association in the District is a colossal web of antitrust offenses under the Fifth Circuit's holding because one cannot hire GHA's podiatrist without taking its dermatologist.

There is, moreover, no way to stop the analysis at the border of medicine. General Motors *could* offer customers a choice of Firestone and Goodrich tires for its cars. Thus if GM puts its tire requirements out for bids, and one year buys only Firestone tires because Firestone made the low bid, it has committed a per se violation of the antitrust laws.

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[6] Nothing in this case turns on the fact that Roux is a separate corporation. The Fifth Circuit's analysis would be equally applicable if the Roux anesthesiologists were employees of the hospital.

2. The decision has substantial importance even if the holding is confined to hospitals. Available data suggest that at least half of all hospitals have exclusive arrangements in radiology, pathology, anesthesiology, or all three; all hospitals hire their nurses and several other medical inputs.

A survey conducted by the AMA[7] found that in 1981 some 78,600 physicians, or 26% of all nonfederal patient-care physicians excluding residents, had contractual arrangements with hospitals. Some of these contracts doubtless are not exclusive, but other physicians must have de facto exclusive arrangements not entailing contracts, so the data are a guide to the scope of the challenged arrangements. Some 78% of the 8,500 pathologists, 58% of the 15,800 radiologists, 27% of the 13,100 anesthesiologists, and 11% of the surgeons reported such arrangements. The average annual net income derived from the arrangements is $114,100 for each of these pathologists (or 96% of pathologists' total annual income), $108,900 for radiologists (or 80%), and $84,400 for anesthesiologists (or 87%). The annual volume of commerce affected by exclusive medical services contracts thus is approximately $2.05 billion for the three hospital-based specialties alone; it is much greater if the contractual income of other medical professionals is included.

The figures look much the same if viewed from the perspective of hospitals. In 1972-74 roughly 20% of hospitals had salaried pathologists and another 40% compensated their pathologists by a percentage of

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[7] American Medical Association, Center for Health Policy Research, *SMS Report* (Feb. 1982).

departmental income (a close proxy for exclusive contracts).[8] For radiologists these figures are 6% employed and 62% so compensated in 1972; 10% employed and 55% so compensated in 1974. (The study did not obtain data for anesthesiologists.) Exclusive contracts seem to predominate in American hospitals. By any measure of importance, then, the court of appeals' judgment requires review by this Court.

3. The court of appeals' decision is as misguided as it is important. The antitrust objection to tie-ins is based on their use of leverage to transfer monopoly power from one product to another. See *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U.S. 610, 617 (1977) (*"Fortner II"*). Leverage is impossible unless there is both monopoly power in the tying good and some mechanism to transfer that power to the tied good. The theory of tie-ins is that the price of the tied good will rise as it partakes of the tying good's monopoly power. As the Court held in *Fortner II*, however, a package sale is not unlawful if the package price is competitive.

Yet respondent has not alleged, and the court of appeals did not find, that the anesthesiology arrangement caused an increase in the price of the operating room/anesthesia "package." Indeed, the court observed that the price of anesthesia had not risen (App. A, *infra*, 11a-12a), and it did not suggest that there was a corresponding rise in the price of operating room time.

This was attributable in substantial part to the allocation of duties between anesthesiologists and nurse anesthetists that the arrangement made possible.

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[8] Data from Paul J. Feldstein & Charles Roehrig, *An Analysis of Exclusive Contracts and Closed Staffing in Hospitals: The Effects on Competition*, a report to the FTC.

Because Roux is solely responsible for anesthesia in the Hospital, it will make an efficient allocation between these services. Thus four anesthesiologists can cover fourteen operating rooms in the Hospital. In an "open" department, by contrast, anesthesiologists will try to supply their own services even though a particular procedure could be performed more effectively, and at lower cost, by the highly-specialized nurse anesthetists who operate under the constant guidance of Roux in the Hospital's "closed" department. An "open" department would destroy both the incentives and the supervision that make these savings possible.

But whatever one makes of the argument that there are efficiencies in the joint supply of operating rooms and anesthesia, the fact remains that the "tie" is not a method of increasing the price received by the anesthesiologist. To the contrary, as the district court found, competition among anesthesiologists to obtain the positions will reduce the price of their services. In this case the Hospital obtained, by contract, complete freedom to set and reduce the fees charged by Roux. Bidding for the position reduces price, which may explain why the American Society of Anesthesiologists apeared as amicus to support respondent.

4. There are at least three mistakes in the Fifth Circuit's treatment of the arrangements. We address them in turn.

a. Tie-in doctrine is simply inapplicable where, as here, the arrangement *creates* the product the Hospital sells. A suit with buttons, a car with tires, an encyclopedia with 25 volumes rather than 1 or 15, all are single products. The fact that the seller could conduct its business so as to multiply the number of products is irrelevant. What makes a tie is the fact that two items, each

independently useful, are put together and the customer coerced to take both even though he needs but one. See, e.g., *Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594 (1953); *Hirsh* v. *Martindale-Hubbell, Inc.*, 674 F.2d 1343 (9th Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-570; and *Principe* v. *McDonald's Corp.*, 631 F.2d 303 (4th Cir. 1980), cert. denied, 451 U.S. 970 (1981), among the many decisions that reject the Fifth Circuit's approach of defining a tie-in by looking for potentially-severable items in a larger bundle. These cases hold, instead, that there is no tie if the products are customarily sold together; surely there is none, they say, if the products are not sold in separate markets.

Under the standard adopted by these cases, the arrangement at issue here is not a tie-in. Operating rooms and anesthesia are not independently useful. The utility of one depends on the supply of the other. There is no market for operations without anesthesia. A patient contracts for "surgery" and depends on the hospital or the surgeon to secure space, blood, oxygen, nurses, anesthesia, and the other essential ingredients of medical care. The patient inevitably sees the transaction as a package deal.[9]

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[9] Respondents doubtless will reply that operating rooms and anesthesiology are separate products because they are priced separately on patients' bills. This cannot be the legal test of multiple products, though. A law firm prices partners' time, associates' time, and expenses separately, yet no one thinks of legal services as a tie-in. Hospitals price oxygen and blood separately, but no one would seriously argue that the joint provision of patients' rooms and oxygen is a tie-in. Hospitals' pricing practices are designed to fulfill requirements of those (insurers and governmental agencies) who pay most bills and to encourage patients who pay their own charges to conserve in their demands on the hospitals' services.

b. Even if the package sale to patients is a tie-in, it is not unlawful unless the tie was used to transfer market power from the tying good to the tied good. For this to occur there must be both power and transfer. Neither is present here.

As we have pointed out above, there is no finding that the tie elevated either the package price or the price of anesthesiology. Without such a finding, there is no market power. The Fifth Circuit's contrary holding conflicts with *Fortner II* and, e.g., *Kypta* v. *McDonald's Corp.*, 671 F.2d 1282 (11th Cir. 1982), cert. denied, Oct. 4, 1982, No. 82-6 (dismissing a case because plaintiff did not allege or prove an elevation in the price of the package). But see *Bell* v. *Cherokee Aviation Corp.*, 660 F.2d 1123 (6th Cir. 1981) (in accord with the Fifth Circuit, finding market power without proof of effect on price).

The fact that people who live near the Hospital prefer to use its services does not establish market power — at least not unless every corner grocery also has market power as a matter of law. A small grocery draws most of its customers from its neighborhood even if it is in the shadow of a large supermarket. The origin of its customers would prove nothing about market power. The same is true here. There is no proof that the Hospital could charge elevated prices because of this preference; the district court found as a fact that it could not (App. B, *infra*, 34a, 38a-39a). The preference of neighbors probably reflects the Hospital's good service and competitive prices rather than monopoly power.

As for the Fifth Circuit's belief that the provision of medical care is noncompetitive as a whole, there are two flaws. First, there is no evidence to this effect in the record, and it cannot be the subject of judicial notice.

This Court's decision in *Arizona* v. *Maricopa County Medical Society*, 102 S. Ct. 2466 (1982), is based on a belief that the provision of medical care is ordinarily competitive. The court of appeals' "evidence" of imperfect competition concerned the lack of complete information, the prevalence of insurance, and other features present in most markets to a greater or lesser degree (App. A, *infra*, 9a). One cannot take the presence of such features as establishing market power without proof; indeed, one probably cannot use them as indicia of market power at all without holding that all markets are noncompetitive.

Second, such a finding would have nothing to do with the tie alleged in this case. If the Hospital has market power vis a vis patients, it can exploit this power whether or not it has a closed anesthesiology department. It could tack a surcharge onto the patient's bill for each anesthesia procedure. If instead of doing this the Hospital allows anesthesiologists to increase their fees, it loses the income it could obtain. A higher cost of anesthesiology would hurt the Hospital as well as the patients. Thus the Hospital's incentives in securing anesthesia are congruent with patients'. Both gain from competition among anesthesiologists.

Because the Hospital's market position vis a vis its patients is unaffected by the way in which it secures or furnishes anesthesia, the right market perspective is the

national market in which the Hospital secures anesthesiology services from professionals, as the Seventh Circuit held in *Dos Santos, supra*, 684 F.2d at 1354,[10] and as *Tampa Electric Co.* v. *Nashville Coal Co.*, 356 U.S. 320 (1961), indicates, rather than the market in which the Hospital serves patients. See also *RCM Supply Co.* v. *Hunter-Douglas, Inc.*, 686 F.2d 1074, 1076-77 (4th Cir. 1982). Surely respondent's "foreclosure" from obtaining one of the four positions at the Hospital did not affect competition in any discernible fashion.

c. Finally, the court of appeals erred in consigning the Hospital's proof of efficiencies, and the district court's findings concerning the benefits of the arrangements, to the "least restrictive alternative" dustbin. Nothing ever passes the least restrictive alternative test, since one can always *imagine* some less restrictive rule that, in a hypothetical world, produces benefits without corresponding costs. "A judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation" (*Illinois Election Board* v. *Socialist Workers Party*, 440 U.S. 173, 188 (1979) (Blackmun, J., concurring)). The degree of economic integration is variable in any business. Some pen manufacturers make their own ink, while others buy ink from specialty firms. Some hospitals have "open" departments of anesthesiology, while most have "closed" departments.

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[10] "The patient . . . receives the services but does so without making any significant economic decision. It may thus be more appropriate for antitrust purposes to treat the *hospital* as the purchaser, in view of the hospital's responsibility for assuring the availability of anesthesia services for its patients . . . . If the hospital . . . is regarded as the purchaser, the relevant market could be defined as the area . . . in which the [hospital] (rather than the patient) can practicably turn for alternative provision of anesthesia services."

A "least restrictive alternative" approach stifles beneficial innovation in the delivery of professional services. One cannot show that any given arrangement is perfect or costless. Nonetheless, the benefits of the arrangement — including most particularly the supervision of the nurse anesthetists — lie at the heart of the case. They illustrate why the Hospital thought exclusive arrangements preferable to an open department. A court cannot sweep them aside as irrelevant (except to a defense that can never be made out) without missing the whole point of tie-in doctrine. Courts call some practices tie-ins because of a belief that putting odd products together in a package hardly ever serves a purpose besides restricting competition. They call other practices (such as selling cars with motors already in them and ball point pens with refills in them) not tie-ins because the gains produced by such prepackaging are apparent. The savings to be had from a practice are pertinent both to the characterization of the practice as a tie-in and to the question whether the practice, so characterized, must be held unlawful per se. Cf. *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36 (1977); *Broadcast Music, Inc.* v. *CBS, Inc.*, 441 U.S. 1 (1979).

The benefits in this case are the same as those of selling cars with motors. They are the benefits of economically-integrated production. As the Court pointed out in *Maricopa*, the antitrust laws are principally directed against naked cartels, not against economic integration. "If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price fixing agreement among the doctors would be perfectly proper." 102 S. Ct. at 2480. Such cooperative medical

coverage is exactly what the Hospital and Roux offer, exactly what the Fifth Circuit held to be illegal per se. That cannot be the law.

CONCLUSION

The writ of certiorari should issue.

Respectfully submitted.

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December 17, 1982

APPENDIX A

DR. EDWIN G. HYDE, PLAINTIFF-APPELLANT,

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 AND EAST JEFFERSON HOSPITAL BOARD, DEFENDANTS-APPELLEES.

No. 81-3091.

UNITED STATES COURT OF APPEALS, FIFTH CIRCUIT.

Sept. 20, 1982.

Appeal from the United States District Court for the Eastern District of Louisiana.

Before GARZA, POLITZ, and WILLIAMS, Circuit Judges.

GARZA, Circuit Judge:

Doctor Edwin Hyde brought this action to challenge his exclusion from the medical staff of East Jefferson General Hospital in Metairie, Louisiana. He sought a declaratory judgment that the actions of the Hospital District and its Board of Directors violated Section 1 of the Sherman Act, 15 U.S.C. § 1; the Due Process clause of the Fourteenth Amendment; Sections 51:122 and 123 of the Louisiana antitrust law; and Section 46:1058 of the state enabling legislation under which the Hospital District was created. Hyde also prayed for the issuance of an injunction ordering defendants to appoint him to the hospital's medical staff. Following a trial on the merits, the court below dismissed the suit. In this appeal,

plaintiff concentrates his attack on the Sherman Act portion of the district court judgment. Today, we reverse the court's judgment, for reasons stated herein. 513 F.Supp. 532.

Doctor Hyde is a board certified anesthesiologist who practices in Jefferson Parish, Louisiana. In July, 1977, he submitted an application for admission to the East Jefferson Hospital medical staff. New staff members are ultimately selected by the East Jefferson Hospital Board. According to the language of La.R.S. 46:1058 concerning the selection of new medical staff, "[s]uch appointments shall be made upon the recommendations of the physicians who are authorized to practice within the hospital." Appellant's application was therefore initially sent to the medical staff, which functions as a separate entity from the hospital. First, the Credentials Committee reviewed Hyde's medical qualifications and submitted a favorable recommendation to the Medical Staff Executive Committee. That committee then reviewed the application and recommended to the Hospital Board that appellant's application be approved. In spite of favorable recommendations from both medical staff committees, the Board voted to deny staff privileges to Dr. Hyde.

This action was occasioned by the fact that the hospital had an exclusive contract with Roux and Associates, a professional medical corporation, to provide anesthesia services.[1] Under the terms of this contract, the anesthesiologist determines the fee for the services

[1] The first contract between the parties was executed in February, 1971, and explicitly granted to Roux the exclusive right to provide anesthesia services. This exclusive language was deleted when the parties entered into a second contract in January, 1976. However, the executive director of the hospital testified that another provision, retained in the 1976 contract, had the same effect

he provides based upon the complexity and length of the operation performed. Patients are billed jointly for the anesthesia services provided by the doctor and by the hospital. The hospital deducts eight percent for bad debts, charity and other write-offs from the gross receipts of the department and then remits fifty percent of the remaining sum to Roux and Associates.

The provision of anesthesia services in each of East Jefferson Hospital's thirteen operating rooms is, in large part, undertaken by nurse anesthetists. At least one hospital-employed nurse anesthetist is assigned to each room. The four anesthesiologists employed by Roux and Associates travel between the rooms as they are needed for supervision. Anesthesia is routinely administered by the nurse anesthetist. An anesthesiologist remains with a patient only for more complicated operations. Appellees aver that the system employed is in the best interest of quality patient care. The monitoring of specialized equipment and supervision of nurses can best be handled, in their estimation, by the closed group policy. This closed group policy also gives the hospital the continuous twenty-four hour a day coverage that is crucial in the event of an emergency.[2] Other arguments made to justify the policy are that it facilitates the use of operating rooms since no waiting for outside anesthesiologists

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as the provision deleted. Regardless of the existence of any exclusive contract between the parties at present, the hospital continues to maintain the type of closed group policy at issue here. There is no question, hence, but that this is indeed a live controversy.

[2] This point of justification is rebutted quite easily, however, since Dr. Kermit Roux, president of Roux and Associates, admitted that he would feel professionally bound to provide such coverage even in the absence of an exclusive contract. It was Dr. Roux, after all, who requested that the exclusive language in the contract be removed. At trial, Dr. Roux explained the reason for his request:

is necessary and that it wisely allows the responsibility for development and management of the department to be placed upon one individual with legal obligations to the hospital. Finally, the appellees assert that the closed group policy permits them to more closely monitor the professional standards employed by the department members.

After a trial on the merits, the district court ordered this suit dismissed. In the corresponding opinion, the

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Q The Judge asked you if in fact when the 1976 contract was negotiated and executed, you asked that the language calling for the exclusion of the other anesthesiologists be deleted from the contract.

A Yes, sir.

Q So that it would no longer be a part of the contract?

A Yes, sir. The reason we did that, there were a number of reasons. There was this other group that had requested to come practice there and led us to believe that some physicians preferred them to give their anesthetics. And if that were true, then I think they should be allowed to practice.

The other reason is pretty much what you have alluded to, I didn't want to be there on the basis of hiding behind a contract. If I couldn't provide the service as best I could, then someone else ought to have a shot at it.

And I had been told by people a number of times that, you're hiding behind the contract because it gives you exclusive privileges "exclusive privileges" and doesn't let anyone else come. And I don't believe that that's the way medicine should be practiced. It should be practiced on the basis of the person whom the physician or the patient feels can do the best job, should be their physician.

So, we finally got them to delete that part of the contract.

Record on Appeal, vol. 3, at 7-8.

After this language was deleted, he continued to provide twenty-four hour a day coverage. Although the hospital's executive director testified that another provision, retained in the 1976 contract, had the same effect as the provision deleted, Dr. Roux did not operate under this interpretation of the contract.

court rejected a *per se* in favor of a rule of reason analysis of this case, stating in the alternative that plaintiff could not prevail on a *per se* analysis because he had not made the necessary demonstration that the hospital "dominated" the market for its services. The court held that relief was unavailable under a rule of reason analysis because the anticompetitive effects of the closed group policy were few and far outweighed by the many benefits to patient care. On appeal, Hyde argues that: (1) the tying arrangement involved is not immune from *per se* liability solely because of the professional nature of the services involved; (2) the district court erred in holding that the defendant hospital must be shown to have dominant power in the tying product market; and (3) the court incorrectly defined the relevant geographic market area for the tying product.[3]

TYING ARRANGEMENT

A tying arrangement is "an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product. . . ." *Northern Pacific Ry.* v. *United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958). The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that users of the hospital's operating rooms (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain

[3] Since we base our decision today exclusively on Section 1 of the Sherman Act, we do not unnecessarily recite the other portions of the lower court's judgment and appellant's challenges thereto.

separately. Our inquiry does not end here; tying arrangements are only proscribed by the Sherman Act when they exhibit the following four characteristics:

(1) two separate products, the tying product and the tied product;

(2) sufficient market power in the tying market to coerce purchase of the tied product;

(3) involvement of a not insubstantial amount of interstate commerce in the tied market; and

(4) anticompetitive effects in the tied market.

Bob Maxfield, Inc. v. *American Motors Corp.*, 637 F.2d 1033, 1037 (5th Cir. 1981). The United State Supreme Court recognized many years ago that "the vice of tying arrangements lies in the use of economic power in one market to restrict competition on the merits in another, regardless of the source from which the power is derived and whether the power takes the form of a monopoly or not." *Northern Pacific Ry.* v. *United States*, 356 U.S. at 11, 78 S.Ct. at 521.

The district judge ruled against appellant on precisely this point. He found that appellant had failed to demonstrate that the hospital dominated the market for its services. However, as the following language from the United States Supreme Court's opinion in *Northern Pacific Ry.* v. *United States, supra*, demonstrates, market domination is not required:

> While there is some language in the Times-Picayune opinion which speaks of "monopoly power" or "dominance" over the tying product as a necessary precondition for application of the rule of per se unreasonableness to tying arrangements, we do not

> construe this general language as requiring anything more than sufficient economic power to impose an appreciable restraint on free competition in the tied product (assuming all the time, of course, that a "not insubstantial" amount of interstate commerce is affected). To give it any other construction would be wholly out of accord with the opinion's cogent analysis of the nature and baneful effects of tying arrangements and their incompatibility with the policies underlying the Sherman Act. Times-Picayune, of course, must be viewed in context with International Salt and our other decisions concerning tying agreements.

Id. at 11, 78 S.Ct. at 521.

Although appellant is correct in his assessment of the economic power necessary to sustain a finding of an illegal tying arrangement, the court's imperfect definition of the relevant geographic market for the hospital's services would prevent him from succeeding on this element, even when a less stringent economic power standard is applied. The court below made the following finding about the relevant geographic market area:

> A relevant geographic market is the market area in which the seller operates and to which the purchaser can practically turn for supplies. The evidence showed that 70% of the patients from the East Bank of Jefferson Parish go to hospitals in the metropolitan Orleans area other than East Jefferson. The data presented by the New Orleans Area/ Bayou River Health System shows large numbers of Jefferson residents go to hospitals in the New Orleans area such as Mercy, Baptist and Touro Hospitals and Hotel Dieu. Therefore plaintiff must show

> that East Jefferson dominated the market which at least includes the Orleans Parish hospitals which are located on the East Bank.

Record on Appeal, vol. 2, at 246-47.

The court applied a traditional method of economic power analysis in this case, recognizing that surgeons have the option of admitting their patients to other hospitals and that patients have a similar right to go to another hospital if they are at all dissatisfied with the anesthesia service offered at East Jefferson Hospital. The contract at issue here involved only one hospital out of at least twenty in the area. Under the analysis applied to a truly competitive market, appellant has failed to prove an illegal tying arrangement. In *U.S. Steel* v. *Fortner Enterprises*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed.2d 80 (1977), the Supreme Court framed the inquiry as

> whether the seller has the power, within the market for the tying product, to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market. In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product.
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> Without any such advantage differentiating his product from that of his competitors, the seller's product does not have the kind of uniqueness considered relevant in prior tying-clause cases.

Id. at 620-21, 97 S.Ct. at 867-68 (footnotes omitted).

Not only the court defined market power standard, but also the area within which the court finds that power operates, determine the extent of the hospital's actual

power. If both patient and surgeon are free to go to any one of a large number of competent institutions, from whence, appellees ask, does the hospital derive the power to force the tied product upon consumers?

The foregoing analysis assumes that the health care industry functions as a competitive market in the same sense as the industries involved in the plethora of other tying cases and should be subject to the same standards.[4] This is not correct. Several market imperfections in the health care industry favor public, non-profit entities like East Jefferson Hospital. First, the prevalence of third party payment of bills eliminates a patient's incentive to compare the relative cost effectiveness of competing hospitals. A second market imperfection is the lack of complete information regarding the quality of medical care offered. Since a patient cannot realistically compare the quality of medical care, he is likely to purchase his medical care from a non-profit entity that has no apparent profit motive to cut quality. It is not surprising that these factors lead patients to select the hospital closest to home, a preference which the court below noted:

> It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go these hospitals if possible.

Record on Appeal, vol. 2, at 247-48.

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[4] *See, e.g., U.S. Steel* v. *Fortner*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed.2d 80 (1977); *Northern Pacific Ry.* v. *United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958); *International Salt Co.* v. *United States*, 332 U.S. 392, 68 S.Ct. 12, 92 L.Ed. 20 (1947); *IBM Corp.* v. *United States*, 298 U.S. 131, 56 S.Ct. 701, 80 L.Ed. 1085 (1936).

The fact that patients tend to choose hospitals by location rather than price or quality, means that the geographical market area for each hospital is much smaller than the district court found. In this case, the court below, while recognizing in one breath patients' preference for hospitals close to home, required appellant to show the economic power of the hospital in a large market area which includes at least twenty other hospitals. We cannot reconcile the judge's findings here; we conclude, therefore, that the judge erred when he defined the geographical market area.[5] Since nearly one-third of the patients from the entire East Jefferson Area go to East Jefferson Hospital, we hold that the hospital does have sufficient market power in the tying market to coerce purchase of the tied product. The propriety of holding that the relevant geographical market area is the East Bank of Jefferson Parish is further shown by the limitation placed on the East Jefferson Hospital Board by state law to serve only the East Bank of Jefferson Parish. The Hospital Board is directed by La.R.S. 46:1055 "[t]o represent the public interest in providing hospital and medical care *in the district.*"

In the course of presenting his case that the exclusive contract between the hospital and Roux and Associates violates the Sherman Anti-Trust Act, Dr. Hyde pointed out a number of "anticompetitive" effects that flow from the agreement. Basic to a discussion of these effects is an understanding of the manner in which the specialty of anesthesiology is practiced. Although the

[5] Amicus curiae, the Louisiana Medical Society, properly points out that this is not the figure which is important for this case. The court should have determined the geographic market in which the hospital competes for the provision of *surgical* facilities. In light of our resolution of the geographic market issue, however, we need not remand the case for a more specific finding.

specialty of anesthesiology is indeed a very important and demanding one, the anesthesiologist is only involved in the medical decision-making process after the initial decision between patient and surgeon that surgery is the indicated course of treatment.[6] It is not surprising, therefore, that an anesthesiologist is normally selected by the surgeon, rather than the patient, based on familiarity gained through a working relationship. Obviously, the surgeons who practice at East Jefferson Hospitals do not gain familiarity with any anesthesiologists other than Roux and Associates. Dr. Hyde argues that his is an especially egregious case because he has a more personal relationship with a great number of his patients than many anesthesiologists. This is because he specializes in obstetric anesthesiology and, more particularly, the administration of epidural anesthetics. The exclusive contract, therefore, prohibits patients as well as surgeons from selecting him. Another twist which is important to an understanding of the specialty, anesthesiologists have been confronted with the growth of a paraprofessional counterpart—the anesthetist. Herein lies the actual basis for the hospital's actions in this case.[7] While it is true that the tying of anesthesia services to operating rooms in the instant case did not lead to a higher charge for anesthesia services, it accomplished just as dramatic an effect by

[6] We recognize that anesthesiologists do work with specialists other than surgeons. However, the vast majority of their work is done in conjunction with surgery; this is the basis for our generalization.

[7] The district judge's determination that strictly quality considerations led the hospital to enter into an exclusive contract is clearly erroneous. Doctor Roux even testified as to the invalidity of the major justification put forth by the hospital. The district court's finding leaves this Court with the clear conviction that a mistake has been committed and is, for that reason, set aside.

increasing the hospital's profit. The hospital realizes a substantial profit from its practice of supplementing a small contract group of anesthesiologists with a much larger group of lower priced anesthetists. Furthermore, this practice lacks candor; the patient is not informed that he will be billed for the services of an anesthesiologist who may have had very little contact with his case.[8]

The exclusive contract spawns a number of anticompetitive effects.[9] First, the tie prevents anesthesiologists from entering that part of the anesthesia services market which the hospital controls. This prohibition of competition not only serves indirectly to artificially limit the number of anesthesiologists in the area, but, more importantly, it reduces the incentive for improving or initiating techniques or procedures. Quality is lowered by this restraint while at the same time the hospital's profit, as demonstrated above, is raised. In the instant case, there was also testimony that the profit motive caused the hospital to hire nurse anesthetists in place of needed anesthesiologists, a practice which dilutes the professional coverage available. Secondly, the tie eliminates the surgeon or patient's choice of anesthesiologist at this hospital. Since one goal of antitrust law is to allow the consumer to make buying decisions

[8] This discussion is by no means intended to denigrate the competence of nurse anesthetists. We simply make note of the all too common practice of an anesthetist performing services which are later billed by an anesthesiologist.

[9] Appellees contend that this contract does not stifle competition, but simply places the competition at a different point. They state that anesthesiology groups compete for this contract, and this ensures high quality and reasonable price for the services. We make no comment on the merits of this assertion because the hospital, in fact, has not permitted this competition since the original contract was signed over ten years ago.

without being subject to economic coercion, this anticompetitive effect is significant in a market where location tends to govern the choice of hospital.[10]

Despite the *per se* characterization of this arrangement, appellees maintain that the business justifications for the contract should insulate them from liability. This Court has recognized such a limited defense in tying arrangement cases, but appellees misstate its scope. An illegal tying arrangement will never be excused if there is a less restrictive way to accomplish the end which the business justification purports to serve. *Carpa, Inc.* v. *Ward Foods, Inc.*, 536 F.2d 39, 47 (5th Cir. 1976). The hospital's justifications for the contract must be examined in this light. A major justification for the contract—to insure continuous coverage—must be eliminated because Dr. Roux testified that he would provide twenty-four hour a day service without a contract. The argument that the contract facilitates the use of operating rooms must also be rejected, since appellees are unable to demonstrate why there is more lag time when

[10] The fourth element necessary to prove an illegal tying arrangement requires a finding of the amount of interstate commerce involved. A finding that "a total amount of business, substantial enough in terms of dollar-volume so as not to be merely *de minimis*, is foreclosed to competitors by the tie. . .," *Fortner Enterprises* v. *United States Steel Corp.*, 394 U.S. 495, 501, 89 S.Ct. 1252, 1258, 22 L.Ed.2d 495 (1969), will satisfy this test. The director of operating rooms at East Jefferson Hospital testified at trial that approximately 875 operations per month were performed at the hospital. Record on Appeal, vol. 2, at 236. Even if one uses the very conservative figure of $100 for anesthesia services, the sum of commerce foreclosed in a year's time amounts to over a mill n dollars. The district court recognized that a significant portion of the sum came through the channels of interstate commerce. The court also noted that supplies and medicine for the department are often provided by out-of-state sellers. Record on Appeal, vol. 2, at 240-41. We leave this finding undisturbed.

additional anesthesiologists are permitted to practice at the hospital. Similarly, the business justification based on the use of specialized equipment and nurse supervision must also fall since appellees fail to successfully bear the burden of demonstrating the superior ability of the closed group in this regard. Any anesthesiologist who sought to practice at this hospital would still have to be approved by the medical staff. This procedure was set up, after all, to screen out the incompetent doctors unable to handle such tasks. Monitoring of the professional competence of the anesthesiologists, another asserted business justification, can be accomplished by the much less restrictive means of relying upon the medical staff, which is already set up to provide this service. The need to place the responsibility for development and management of the department upon one individual can also be accomplished without an exclusive contract. In sum, appellees have failed to provide this Court with one reason for the exclusive contract which could not be resolved by a much less drastic solution.

Per Se Liability

Although this practice must be properly characterized as an illegal tying arrangement, appellees argue for a rejection of the stringent *per se* rule of liability traditionally applied in such cases. As justification for this departure from established precedent, they assert that since the judiciary has had little antitrust experience in the health care industry, a rule of reason approach is preferable.[11] They also contend that the professional

[11] In *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 38 S.Ct. 242, 62 L.Ed. 683 (1918), Justice Brandeis set forth the following classic statement of the rule of reason:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or

nature of the services mandates a rejection of the rigid *per se* rule. The Supreme Court's recent opinion in *Arizona* v. *Maricopa County Medical Society*, —— U.S. ——, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982), however, forecloses both arguments. That decision dealt with the *per se* rule as applied to price-fixing in the health care industry; its rationale is equally applicable to tying arrangements.[12]

> Nor does the fact that doctors—rather than nonprofessionals—are the parties to the price fixing agreements support the respondents' position. In *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 788, n.17 [95 S.Ct. 2004, 2013, n.17, 44 L.Ed.2d 572] (1975), we stated that the "public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." See *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 [98

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whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

Id. at 238, 38 S.Ct. at 244.

[12] The courts have declared the following practices unlawful in and of themselves and, therefore, subject to the *per se* rule: price fixing, division of markets, groups boycotts, and tying arrangements. *Northern Pacific Ry. Co.* v. *United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 518, 2 L.Ed.2d 545 (1958).

S.Ct. 1355, 1367, 55 L.Ed.2d 637] (1978). The price fixing agreements in this case, however, are not premised on public service or ethical norms. The respondents do not argue, as did the defendants in *Goldfarb* and *Professional Engineers*, that the quality of the professional service that their members provide is enhanced by the price restraint. The respondents' claim for relief from the *per se* rule is simply that the doctors' agreement not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services.

We are equally unpersuaded by the argument that we should not apply the *per se* rule in this case because the judiciary has little antitrust experience in the health care industry. The argument quite obviously is inconsistent with [*U.S.* v.] *Socony-Vacuum* [*Oil Co.*, 310 U.S. 150, 60 S.Ct. 811, 84 L.Ed. 1129]. In unequivocal terms, we stated that, "[w]hatever may be its peculiar problems and characteristics, the Sherman Act, so far as price-fixing agreements are concerned, establishes one uniform rule applicable to all industries alike." 310 U.S., at 222 [60 S.Ct. at 843]. We also stated that "[t]he elimination of so-called competitive evils [in an industry] is no legal justification" for price fixing agreements, *id.*, at 220, [60 S.Ct. at 843] yet the Court of Appeals refused to apply the *per se* rule in this case in part because the health care industry was so far removed from the competitive model. Consistent with our prediction in *Socony-Vacuum*, *id.*, at 221 [60 S.Ct. at 843] the result of this reasoning was the adoption by the Court of Appeals of a legal standard based on the reasonableness of the

fixed prices, an inquiry we have so often condemned. Finally, the argument that the *per se* rule must be rejustified for every industry that has not been subject to significant antitrust litigation ignores the rationale for *per se* rules, which in part is to avoid "the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large whether a particular restraint has been unreasonable—an inquiry so often wholly fruitless when undertaken." *Northern Pac. R. Co.* v. *United States, supra*, [356 U.S.] at 5 [78 S.Ct. at 518].

102 S.Ct. at 2475-77.

Similarly unpersuasive to the Supreme Court in *Arizona* v. *Maricopa County* was defendant's principal argument that the agreements should be immune from *per se* liability because of the procompetitive justifications therefor, an argument which is urged strenuously in this appeal.[13] The asserted procompetitive justifications for the exclusive contract between the hospital and

[13] The Court concluded that this argument was more properly directed to Congress:

> Our adherence to the *per se* rule is grounded not only on economic prediction, judicial convenience, and business certainty but also on a recognition of the respective roles of the Judiciary and the Congress in regulating the economy. *United States* v. *Topco Associates, Inc., supra*, [405 U.S. 596] at 611-612 [92 S.Ct. 1126 at 1135, 31 L.Ed.2d 515]. Given its generality, our enforcement of the Sherman Act has required the Court to provide much of its substantive content. By articulating the rules of law with some clarity and by adhering to rules that are justified in their general application, however, we enhance the legislative prerogative to amend the law. The respondents' arguments against application of the *per se* rule in this case therefore are better directed to the legislature. Congress may consider the exception that we are not free to read into the statute.

Roux and Associates are identical to the business reasons which were proposed to justify the contract. The following quote demonstrates why the procompetitive justifications offered by appellees do not warrant a departure from the *per se* rule.

> The argument indicates a misunderstanding of the *per se* concept. The anticompetitive potential inherent in all price fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some. Those claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application. Even when the respondents are given every benefit of the doubt, the limited record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition.

102 S.Ct. at 2477 (footnote omitted).

CONCLUSION

Inasmuch as we declare that this exclusive contract creates an illegal tying arrangement, we must also grant the requested injunction and permit Dr. Hyde to practice his chosen profession. The medical staff at East Jefferson Hospital highly recommended that he be granted staff privileges.[14] The refusal of the hospital board to grant staff privileges was based on the existence of the exclusive contract with Roux and Associates.

Id. 102 S.Ct. at 2478-79 (footnote omitted).

[14] We concur with the following statement from *Sosa* v. *Board of Managers of Val Verde Hospital*, 437 F.2d 173 (5th Cir. 1971), about the propriety of judicial restraint where the professional and ethical competence of a physician is concerned.

> In the instant case there was considerable evidence regarding Dr. Sosa's ethical and professional competency. No court should

This opinion does not test the limits of access to staff privileges. Certainly, the staff size of each hospital is bounded by legitimate concerns of overcrowding, overtaxing of hospital personnel and resources, and the consequent decline in quality of patient care. In the instant case, however, it was not the size of the department which concerned the hospital board, but the profit which the current structure generated. In addition, the concerns which allegedly led to the implementation of the exclusive contract can be addressed by much less restrictive alternatives. They furnish an illusory basis for depriving a physician of the right to practice his profession.

For the reasons set forth above, the district court's judgment in this matter is reversed.

REVERSED.

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substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff.

Id. at 177.

APPENDIX B

DR. EDWIN G. HYDE

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 And THE EAST JEFFERSON HOSPITAL BOARD.

Civ. A. No. 78–750.

UNITED STATES DISTRICT COURT,
E. D. LOUISIANA.

Jan. 23, 1981.

MITCHELL, District Judge.

This matter was tried to the Court on a former date. The Court now makes the following written findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

FINDINGS OF FACT

I.

Plaintiff, Dr. Edwin G. Hyde, is a medical doctor, licensed to practice by the State of Louisiana. Dr. Hyde is board certified in anesthesiology and is engaged in the practice of that specialty, primarily doing obstetric work at Lakeside Hospital in Metairie, Louisiana.

II.

Defendant Jefferson Parish Hospital District No. 2 (hereinafter the District) is a political subdivision of the State of Louisiana, created by the Jefferson Parish Council in accordance with the provisions of La.R.S.

46:1051 et seq. The District owns East Jefferson General Hospital (hereinafter East Jefferson) which was constructed with public monies. The Jefferson Parish Council is the governing authority of the District and has delegated its responsibility to operate East Jefferson to a twelve man Board of Directors (hereinafter the Board) which has the ultimate responsibility for the quality of medical care provided by the hospital. The Board appoints an executive director to carry out its policies in the daily operations of the hospital. Mose Ellis has been employed as the Executive Director of the hospital since January, 1968 which was prior to the hospital's construction.

III.

The by-laws of East Jefferson Hospital provide for the appointment of a separate body, the Medical Staff, which consists of the heads of various medical departments in the hospital. The Medical Staff develops its own set of rules and by-laws, which are subject to ratification by the Board.

Physicians applying for medical staff privileges must submit an application to the hospital director. The accuracy of the information given is checked by hospital employees and the application is then forwarded to the Credentials Committee of the Medical Staff for review of the applicant's qualifications. That Committee then makes a recommendation to the Medical Executive Committee which in turn makes a recommendation to the Board of Directors.

Pursuant to the by-laws of the hospital and the medical staff the Board makes the ultimate determination with regard to the appointments of physicians to the

medical staff with the limitation that it must make its choices from physicians who receive recommendations from the medical staff.

IV.

East Jefferson entered into a contract with Roux & Associates, a professional medical corporation, to provide anesthesia services to the hospital prior to its opening in February, 1971. The contract provided that the anesthesia services would be exclusively provided by Roux and Associates and that members of the group would not provide its services elsewhere without the written authorization of the hospital. The Board felt that a closed group policy was in the best interest of quality patient care. Ellis testified that it was determined that a closed system would be more advantageous because anesthesiology is a hospital based specialty and the Board was of the opinion that the responsibility for the development and management of the department should be placed upon one individual with legal obligations to the institution. Other reasons given for choosing that system were that the supervision of some twenty nurses and the monitoring of specialized equipment could best be handled by one individual or group always present at the hospital. The hospital felt it necessary to have a group on call for twenty-four hours a day so that it could be assured of the presence of a physician in the event of an emergency arising. The closed system would also facilitate the scheduling of operations and result in a more efficient use of operating rooms since there would be no delay while waiting for outside anesthesiologists to arrive. The Board also felt a closed system would allow them to closely monitor the medical standards employed by the members of their department. The medical staff was well satisfied with the system under

Roux and Associates and the Board wished to continue under the same conditions. Ellis stated that a patient was free to go to another hospital if he desired to use a particular anesthesiologist who is not on East Jefferson's staff.

V.

The hospital entered into a second contract with Roux and Associates in January 1976. At Dr. Roux's request the language designating the contract as an exclusive one was omitted. However, in another section, the contract continued to provide that all anesthesia services at the hospital were to be provided by the Roux group. Ellis stated that at no time did the Board express an intent to change its policy with regard to the closed system. Ellis had no firsthand knowledge of the Roux doctors practicing elsewhere though he had heard rumors that such was occurring. Ellis stated that doctors who are not on the East Jefferson medical staff could apply for temporary privileges to practice on a case by case basis.

VI.

Ellis testified that the hospital charges patients one fee for the professional services rendered by the anesthesiologist and for the anesthesia services provided by the hospital. The hospital pays the salaries of the nurses and purchases the equipment and supplies for the anesthesia department. A large number of the supplies are purchased from out of state. It also provides housekeeping, record keeping and maintenance services to the department.

The anesthesiologist determines the fee for the anesthesia service provided dependent upon the complexity and length of the operation performed. The hospital

deducts 8% for bad debts, charity and other write offs from the gross receipts of the department and 50% of the remainder is paid to Roux and Associates for its professional services. Ellis testified that it was in accord with hospital industry practice to pay hospital based specialists a certain percentage of the receipts. Ellis also testified that the anesthesiology department generally made a profit but that the purpose of the closed anesthesiology department was to provide quality patient care and not for the financial profit of the hospital.

Ellis testified that anesthesia services were often paid in part by federal medicare and medicaid benefits.

VII.

Dr. Kermit Roux formed Roux and Associates in 1970 and began work at East Jefferson in 1971. Roux testified that he requested the omission of the exclusive language in his 1976 contract because he believes a surgeon or patient is entitled to the services of the anesthesiologist of his choice. He admitted that he and others in his group did work outside East Jefferson following the 1976 contract but felt he was not in violation of the contract in light of the changes made in it.

Roux testified that he employed three other doctors in his group and that there are usually thirteen or fourteen certified registered nurse anesthetists (CRNA's) on duty during operations. CRNA's are registered nurses with two years training as anesthetists. They are used in every hospital in the New Orleans area because there are more hospitals than anesthesiologists in Louisiana.

Dr. Roux testified that the anesthesiologist prescribes the anesthetic to be given and the equipment to be used. The doctor administers the drugs and remains in the operating room until he is confident the patient is in

stable condition. He then goes to another operating room leaving the nurse to monitor the patient. The doctor again checks the patient in the recovery room. In Roux's opinion neither the hospital nor its nurses are engaging in the practice of medicine.

Roux was unaware of any complaints being made about his group's services.

VIII.

Dr. Edwin Hyde submitted an application for medical staff privileges to the hospital on July 14, 1977. The Credentials Committee approved his credentials and qualifications and referred the application to the Medical Executive Committee which considered his qualifications and forwarded his application to the Board of Directors with a recommendation of approval.

A Board of Directors meeting was held on September 20, 1977 and the minutes reflect there was discussion with regard to the application of Dr. Hyde to the anesthesiology department. It was noted that Hyde would not be a member of the Roux and Associates group and a motion was made to table the application for further study.

A Board meeting was held on October 18, 1977 and the Hyde application was presented for action. The Board denied the application after a discussion with regard to the benefits of an exclusive contract with hospital based specialists and the Board concluded that a closed system was in the best interest of the hospital and quality patient care.

Ellis wrote Dr. Hyde on October 19, 1977 and informed him that he had not been accepted for medical

staff membership due to the exclusive nature of the contract between the hospital and Roux and Associates and because there were no openings in the Department of Anesthesia. Ellis stated that in giving the second reason he meant that Dr. Roux had no membership openings in his group.

Dr. Hyde was not told of any right to appeal his decision nor provided with a copy of the hospital's by-laws.

IX.

Dr. Charles Eckert is an anesthesiologist employed by Roux and Associates. He also did some work at Lakeside Hospital in 1977 and 1978. Eckert wrote a letter of recommendation to East Jefferson on Dr. Hyde's behalf. It is his opinion that a patient should be given the right to choose his anesthesiologist.

Eckert stated that the Roux group had requested that the exclusive language be removed from its contract because the group was being criticized by their peers for acting unethically.

However, other than that criticism, Eckert stated there had been no other problems with the closed anesthesiology department which is a common practice in the majority of hospitals in the area. He believes such a department is advantageous because the same individuals are working together daily as a team and the technicians learn to anticipate the manner in which the doctors proceed. Eckert also was of the opinion that it provides flexibility in the scheduling of operating rooms because the hospital does not have to postpone activity while waiting for another group to arrive. It is also easier to have one group operate and maintain the equipment used since they are immediately aware of any problems

and can have them remedied. Eckert stated that members of his group had used Lakeside's equipment without any difficulty but that it is not as complex as the equipment used at East Jefferson where more difficult surgeries are performed.

Eckert testified that there are one hundred fifty-six anesthesiologists in Louisiana and three hundred forty-five hospitals with operating rooms. He testified that in order to have an anesthesiologist present at every operation, East Jefferson would have to employ more than twelve anesthesiologists on its staff.

X.

Mrs. Melvaize Tedeschi is the Director of Operating Rooms at East Jefferson Hospital. She stated that the hospital performs approximately 875 operations per month. She testified that there are generally twelve or thirteen operating rooms in use at one time and four anesthesiologists working. Tedeschi is of the opinion that the nurses are well mointored and has heard many compliments given to the Roux group. She is of the further opinion that if there were outside anesthesiology groups working at the hospital it would decrease the flexibility in scheduling of operations. She also pointed out that if an operation was cancelled there might be a waiting period until the next doctor arrives.

XI.

Dr. John Rourke has been a member of the East Jefferson Board since it was formed. He testified that the Board always assumed that certain departments would be administered by a single group which would develop that department.

Rourke stated that he knew that at one point Touro Hospital had used two separate groups and had experienced problems with competitiveness between those groups. The problems began because the surgeons would generally give priority to one group and he would then have problems dealing with the other group because they felt they were second choice. Touro eventually entered into a contract with one group.

Rourke stated that problems arise because the physicians all want to begin at the same time and also in the absence of a contract there may not be an anesthesiologist available in an emergency situation, thus placing a patient's health at risk.

Rourke stated the Board and staff were pleased with the work of the Roux group and wanted to continue to have a contract with them to guarantee their availability and the best patient care.

Dr. Rourke testified that a patient is paying a medical fee for the expertise of the anesthesiologist in prescribing the drugs used and performing complex procedures. He stated that the nurses merely monitor the patient's progress during the operation and are not making critical medical determinations.

Dr. Rourke stated that East Jefferson is not a charity hospital and the hospital's operating revenues are obtained from the patient's payments for services rendered. It is a public hospital because it was constructed with community funds.

XII.

Nicholas Gagliano has also been a member of the Board of Directors since the inception of the hospital.

He testified that the Board has had continued input from the medical staff with regard to the merits of the closed system anesthesiology department and that the Board has re-evaluated its policy and has continued to find that the closed system is the best manner to operate to insure the twenty-four hour availability of quality anesthesia services.

He testified that the hospital has informed the Roux group that it is in violation of its contract to practice elsewhere.

XIII.

Dr. John Andriani has been practicing anesthesiology at Charity Hospital for forty years. He organized the CRNA training program and established the anesthesiology residency at Charity.

Dr. Andriani testified that he is opposed to the closed anesthesiology departments because a patient loses a right to select the anesthesiologist of his choice and also causes competent physicians to lose jobs. He opined the lack of competition within a hospital will discourage the group with the exclusive contract from improving or initiating new techniques and procedures. Andriani also believes that the closed system discourages anesthesiologists from coming to New Orleans and medical students from entering the field because of a lack of positions in this area.

Andriani is also of the opinion that the hospitals are employing CRNA's and improperly charging patient's medical fees for their services. He believes that one anesthesiologist should supervise no more than three and at most four nurses during operations.

XIV.

Dr. Edwin Hyde practiced anesthesiology in Florida and at Baptist Hospital, New Orleans, for seven years prior to joing the staff at Lakeside Hospital in 1971. He is associated with two other anesthesiologists at Lakeside. However, Lakeside Hospital has an open department and other anesthesiologists regularly practice there. Hyde testified that a booking secretary schedules the Lakeside operations and there is no problem with outside anesthesiologists coming in to work. He stated that similar systems had worked in the Florida hospital where he worked and at Baptist Hospital without any difficulties.

Hyde does not have a contract with Lakeside Hospital. He bills his patients separately and his group employs its own nurses. The hospital has a maintenance contract on the equipment and any problems with it are reported to Hyde since he is the chairman of the Department. Hyde stated that this system operates without any problems.

Hyde stated that he would continue his separate billing procedure at East Jefferson but would only bring his own nurses if he was doing a complex surgery. The majority of his work at Lakeside is obstetrics and he feels he could attract more doctors to his group if he could do different types of surgery at another hospital. He is of the opinion that exclusive contracts discourage anesthesiologists from coming into the area because they limit the openings at hospitals.

XV.

Jessie Smallwood, executive director of the Bayou River Health Systems presented data showing which hospitals the patients residing in certain zip code areas

attend over various time periods. Her information was incomplete because at various times certain hospitals did not participate in the surveys. There is also no information with regard to which patients had surgery.

The data showed that approximately seventy per cent (70%) of the patients who are residents of Jefferson Parish entered hospitals located in the metropolitan New Orleans area other than East Jefferson. Seventy per cent (70%) of the patients entering East Jefferson are residents of East Bank Jefferson Parish. Several hundred patients from out of state were admitted to East Jefferson Hospital in 1978 and 1979.

XVI.

Based on the evidence presented the Court concludes that the Board of Directors was acting within its statutory authority under state law and the hospital's by-laws in not adopting the medical staff's recommendation and denying Dr. Hyde medical staff privileges.

XVII.

The Court also finds that the portion of the anesthesia fees retained by the hospital bears a reasonable relationship to the services and materials provided by the hospital in connection with anesthesiology services.

The Court finds that the hospital did not improperly engage in the diagnosis and treatment of patients. The evidence shows that the anesthesia services are provided by the anesthesiologist who prescribes the drugs used and performs all procedures requiring expertise. The CRNA's work under the supervision of the anesthesiologists and their function is to monitor the patients while they are anesthetized.

XVIII.

The evidence shows that in the operation of its anesthesia department the defendants are involved in activities which have a not insubstantial effect on interstate commerce. These include buying anesthesia medicines and other supplies from out of state, the receipt by patients of federal medicare and medicaid benefits to pay for anesthesia services and the treatment of out of state patients who require anesthesia services.

XIX.

The evidence presented was that it is a common practice in the health care industry for hospitals to enter into exclusive contracts with physicians who are engaged in certain hospital based specialties, such as anesthesiology, radiology, pathology, etc. to insure the availability of these services to their patients. Generally a patient does not specifically select a certain individual to perform these services, which increases the hospital's responsibility to insure the quality of services it provides.

The evidence presented was that defendants instituted a closed system anesthesiology department because they believed the system resulted in the best quality of patient care. Specifically the system insures twenty-four hour anesthesiology coverage, aids in the control and standardization of procedures and the efficient and less costly operation of the department; it lends flexibility to the scheduling of operations because it is not necessary to accommodate physicians with outside commitments; it permits the physicians, nurses and other technicians in the department to develop a work routine and a proficiency with the equipment they use in patient treatment; and it increases the Board's

ability to monitor the medical standards exercised because there are fewer individuals involved, maintenance of equipment is simplified and equipment breakdowns are minimized by limiting use to one group of physicians.

The Court does not find that the Board's motive in continuing the closed system is purely a pecuniary one. If that was its only motive it could retain a contract with one group continuing its present billing procedure and still allow other anesthesiologists to come in to practice. It appears to the Court that the Board feels that the closed system department is the best to employ to carry out their obligation to the public to offer the highest quality of medical care.

The Court concludes that the benefits discussed above support a finding of reasonableness that justifies the exclusive arrangement between the defendants and Roux and Associates.

XX.

The provision of anesthesia services is a medical service separate from the other services provided by the hospital. The hospital charges the patient a separate charge for this service.

The geographic area in East Jefferson competes in the New Orleans metropolitan area. Large numbers of patients from Jefferson Parish use the hospitals in Orleans Parish. Seventy per cent (70%) of the patients living in East Bank Jefferson Parish go to hospitals other than East Jefferson. The Court concludes that East Jefferson is competing for business at least with the hospitals located on the East Bank in Orleans Parish.

XXI.

The evidence presented did not show that East Jefferson had any advantages over any other hospitals in the area because it is a public hospital. Due to that fact (the hospital was built with public funds) however, it is not a charity hospital and its daily operations are financed by patients' payments for hospital services. There was no evidence presented that East Jefferson was in a position to charge patients higher prices or to impose burdensome terms which could not be exacted in a completely competitive market. There was no evidence that East Jefferson was a dominant economic power in the market in which it competes.

The impact on commerce resulting from the East Jefferson contract is minimal. The contract is restricted in effect to one hospital in an area containing at least twenty others providing the same surgical services. It would be a different situation if Dr. Roux had exclusive contracts in several hospitals in the relevant market. As pointed out by plaintiff, the majority of surgeons have privileges at more than one hospital in the area. They have the option of admitting their patients to another hospital where they can select the anesthesiologist of their choice. Similarly a patient can go to another hospital if he is not satisfied with the physicians available at East Jefferson.

A closed department may enhance competition among the hospitals in the market by increasing the quality of medical care available. It may also serve to benefit competition among anesthesiology groups if the terms of the exclusive contracts are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals.

The Court concludes that the purpose of the exclusive contract is to enhance patient care and its restraint on competition in the field of anesthesiology is minimal.

CONCLUSIONS OF LAW

I.

The Court has jurisdiction over this action pursuant to the provisions of 28 U.S.C. § 1337 and 28 U.S.C. § 1343(3) and pendant jurisdiction over the state law claims.[1] Venue is properly laid in this district.

II.

The Sherman Antitrust Act prohibits every contract, combination or conspiracy which unreasonably restrains trade or commerce among the several states.[2] It encompasses far more than restraints on trade that are motivated by a desire to limit interstate commerce or that have their sole impact on interstate commerce. Wholly local business restraints can produce the effects condemned by the Act as long as the activity is an inseparable element of a larger program dependent for its success upon an activity which affects commerce between the states.[3]

Although it may have an effect on the determination of a violation of the Sherman Act, neither the nature of

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[1] *United Mine Workers v. Gibbs*, 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966).

[2] 15 U.S.C. § 1.

[3] *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004, 44 L.Ed.2d 572 (1975); *Gulf Oil Corporation* v. *Copp Paving Company*, 419 U.S. 186, 95 S.Ct. 392, 42 L.Ed.2d 378 (1975); *United States* v. *Employing Plasterers Association*, 347 U.S. 186, 74 S.Ct. 452, 98 L.Ed. 618 (1954).

an occupation nor the public service aspect of a professional practice is controlling in determining whether or not the Act initially applies.[4] The payments exchanged for professional services constitute trade or commerce and, if the commerce involved is interstate in character, it is subject to the jurisdiction of the Sherman Act.[5]

A substantial effect on interstate commerce to satisfy the Act's jurisdictional requirements has been found in the health care field where the challenged activity has some effect on the purchase of out-of-state medicines and supplies, the receipt of federal medicare and medicaid benefits and the treatment of out-of-state patients.[6] The evidence presented showed that East Jefferson Hospital made these interstate contacts in the course of the operations of its anesthesia department and the Court finds that these contacts had a not "insubstantial effect" on interstate commerce. Therefore we find jurisdiction under the Sherman Act.

III.

Plaintiff contends that the defendants have established a "tying arrangement" by tying the purchase of

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[4] *Goldfarb* v. *Virginia State Bar, supra; National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 98 S.Ct. 1355, 55 L.Ed.2d 637 (1978); Horan and Nord, "Application of the Anti-trust Laws to the Health Care Delivery System", 9 *Cumberland Law Review*, 665 (1979).

[5] *Ballard* v. *Blue Shield of Southern W. Va., Inc.*, 543 F.2d 1075 (CA4–1976).

[6] *Hospital Building Company* v. *Trustees of Rex Hospital*, 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976); *Boddicker* v. *Arizona State Dental Association*, 549 F.2d 626 (CA9–1977); *Zamiri* v. *William Beaumont Hospital*, 430 F.Supp. 815 (E.D.Mich.1977); *Feminist Women's Health Center, Inc.* v. *Mohammad*, 415 F.Supp. 1258 (N.D.Fla.1976).

anesthesia services to the provision of hospital surgical facilities and that such agreement is illegal per se. We are of the opinion that the per se rules used in anti-trust cases governing regular commercial activities should not be made automatically applicable to cases involving professional activities. This will be discussed later in the opinion. However, the Court will discuss the elements involved in determining whether or not the tying agreement is illegal per se in the event an appellate court should disagree on this issue, which involves a relatively new area of law.

An agreement by a party to sell one product but only on the condition that the buyer also purchases a different or tied product, or at least agrees that he will not purchase the product from any other supplier, is a tying agreement.[7] Such agreements serve hardly any purpose beyond the suppression of competition. Tying agreements are unreasonable in and of themselves whenever a party has sufficient economic power with respect to the tying product to appreciably restrain free competition in the market for the tied product and a "no insubstantial amount" of interstate commerce is affected.[8] Where a seller has no control or dominance over the tying product so that it does not represent an effective weapon to pressure buyers into taking the tied item, any restraint of trade attributable to such arrangement is insignificant [9] Indicia of economic power in the market is the

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[7] *Northern Pacific Railway Company* v. *United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958).

[8] *Spartan Grain & Mill Company* v. *Ayers*, 581 F.2d 419 (CA5–1978).

[9] *U. S. Steel* v. *Fortner Enterprises, Inc.*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed.2d 80 (1977).

ability of the seller to raise prices or to impose burdensome terms on purchasers which could not be exacted in a completely competitive market.[10] Another indication would be the uniqueness of the tying product (surgical procedures) which prevents the competitors from offering an equivalent product or services.[11] A third sign is that a substantial number of purchasers have accepted this agreement and there is no explanation for it other than the economic power of the seller.[12]

A relevant geographic market is the market area in which the seller operates and to which the purchaser can practically turn for supplies.[13] The evidence showed that 70% of the patients from the East Bank of Jefferson Parish go to hospitals in the metropolitan Orleans area other than East Jefferson. The data presented by the New Orleans Area/Bayou River Health System shows large numbers of Jefferson residents go to hospitals in the New Orleans area such as Mercy, Baptist, and Touro Hospitals and Hotel Dieu. Therefore plaintiff must show that East Jefferson dominated the market which at least includes the Orleans Parish hospitals which are located on the East Bank. This plaintiff has failed to do. No evidence was presented that East Jefferson imposes any higher prices or imposes any more burdensome terms on its patients than other hospitals in the area. If the use of CRNA's in their anesthesia department is not a favorable procedure, it is one, according to the evidence, which is imposed by all hospitals in the area.

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[10] id.

[11] *Moore* v. *Jas. H. Mathews & Co.*, 550 F.2d 1207 (CA9–1977).

[12] id.

[13] *U. S.* v. *Phillipsburg National Bank & Trust Company*, 399 U.S. 350, 90 S.Ct. 2035, 26 L.Ed.2d 658 (1970).

It does not appear from the evidence that the fact that the hospital is a public one gives it any advantage over others in the area other than that it was built with public funds. It is not a charity hospital and patients pay the same fees as they would pay elsewhere. There was no evidence that the surgical procedures available at East Jefferson are not available at other area hospitals or that the others could not provide equivalent services.

Plaintiff dwells heavily on the fact that seventy (70%) per cent of East Jefferson's patients are residents of the East Bank of Jefferson Parish. It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go to those hospitals if possible. The Court does not find that this factor is proof that East Jefferson is a strong economic power in the market in which it competes.

Based on the above analysis, the Court rejects plaintiff's argument that the agreement involved herein is illegal per se.

IV.

The United States Supreme Court in *Goldfarb* v. *Virginia State Bar*,[14] rejected the idea of professional occupational exemption from the anti-trust laws but intimated that a different standard should be applied to professional services in a now often cited footnote. The Court stated:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view

[14] *Goldfarb* v. *Virginia State Bar, supra*, n.3.

> the practice of professions as interchangeable with other business activities, and automatically to apply to the professions anti-trust concepts which originated in other areas. The public service aspect may require that a particular practice, which could be properly viewed as a violation of the Sherman Act in another context, be treated differently.[15]

In light of that footnote the Court and commentators have suggested that the activities of professional groups should be analyzed according to the rule of reason even though the conduct might be considered a per se violation in another context.[16] Relying on the rule of reason, several courts have upheld the use of exclusive contracts in providing certain medical services to hospitals prior to the *Goldfarb* decision.[17]

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[15] Id. at 788–89, Footnote 17.

[16] *Boddicker* v. *Arizona State Dental Association, supra* at note 6; *Veizaga* v. *National Board for Respiratory Therapy*, 1977—1 Trade Cas. 61, 274 (N.D.Ill.1977); Tyler, "Goldfarb v. Virginia State Bar: The Professions Are Subject to the Sherman Act", 41 *Mo.Law Review*, 1, 11 (1976); "Application of the Antitrust Laws to Anticompetitive Activities by Physicians", 30 *Rutgers Law Review* 991 (1977), *see* Horan and Nord at note 4.

[17] *Datillo* v. *Tucson Gen. Hospital*, 23 Ariz. App. 392, 533 P.2d 700 (Ariz.App.1975) (exclusive contract to provide nuclear medicare services); *Letsch* v. *Northern San Diego County Hospital District*, 55 Cal.Rptr. 118, 246 Cal.App.2d 673 (1963) (closed radiology department held reasonable and lawful); *Blank* v. *Palo Alto Stanford Hospital Center*, 44 Cal. Rptr. 572 (1965) (exclusive contract with diagnostic x-ray department held reasonable and proper method of operating a department); *Benell* v. *City of Virginia*, 104 N.W.2d 633 (1960) (closed radiology department was not arbitrary or unreasonable but in furtherance of hospital's duty to operate efficiently and economically); also see *Radiology Prof. Corp.* v. *Trinidad Area Health*, 577 P.2d 748 (Colo.1978).

In post *Goldfarb* cases different types of analysis have been suggested in applying the rule of reason to professions. One Court held that in order to survive a Sherman Act challenge "a particular practice of a profession . . . must serve the purpose for which the profession exists, viz, to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the challenge."[18] Other factors to be considered are the motive underlying the challenged restraint, as well as the relative positive and negative effects, the powers of the parties on the market they serve and whether other less restrictive means could be employed to achieve the same desired results.[19]

The Supreme Court in its first post *Goldfarb* decision, *National Society of Professional Engineers* v. *U.S.*,[20] implied that the inquiry of the Court in applying the rule of reason is not directed toward the justification of the anticompetitive practice, but rather toward determining whether the challenged practice has an anticompetitive effect.

We have noted in our findings of fact that there are many benefits arising from the closed system which result in improved patient care. We do not believe that the motive behind the system is a pecuniary one, as suggested by plaintiff. Any profits made in the department are put back into the hospital. It is not a situation where a certain individual or group is benefiting financially from the system. The motive appears to be to

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[18] *Boddicker* v. *Arizona Dental Association, supra* at note 6.

[19] *Hennessy* v. *National Collegiate Athletic Assoc.*, 564 F.2d 1136 (CA5–1977).

[20] *National Society of Professional Engineers* v. *U. S., supra* at note 4.

continue a system which has resulted in the operation of a successful department providing excellent health care. An open department would result in a loss of several of the advantages flowing from the system discussed in our fact findings.

We also find that the anticompetitive effect on the practice of anesthesia in the relevant market area is minimal. The East Jefferson group does not enjoy a monopoly nor does it control a substantial share of the provision of services in the relevant area. As far as the Board is concerned the Roux group practice is limited to East Jefferson Hospital. The contract does not prevent Dr. Hyde or any other anesthesiologist from practicing in any hospital other than East Jefferson in the relevant market area. This Court tends to agree with the suggestion of a commentator [21] that "exclusive relationships, such as those between hospitals and certain speciality services, can properly be characterized as enhancing competition by improving a hospital's ability to provide competent health care competitively."

V.

The Louisiana anti-trust laws provide that every contract in restraint of trade or commerce is illegal.[22] In interpreting its anti-trust laws, the Louisiana courts have looked to the federal jurisprudence for guidance.[23]

We conclude that there has been no unreasonable restraint of trade under the federal laws and that there has been no restraint in violation of the state anti-trust laws.

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[21] See Horan and Nord, *supra* at note 4.

[22] La.R.S. 51:122.

[23] *Loew's Inc.* v. *Don George, Inc.*, 110 So.2d 553 (La.1959).

VI.

The operation of a public hospital, such as East Jefferson, constitutes state action and is subject to the requirements of the Fourteenth Amendment.[24]

The Fourteenth Amendment requires a public hospital to afford substantive due process to an applicant for admission to a medical staff.[25] Substantive due process requires the hospital to consider applicants only on grounds that are reasonably related to the purpose of providing adequate medical care.[26] Courts have found that exclusive contracts between a public hospital and some of its staff members to operate a certain specialized facility to the exclusion of other physicians equally qualified are not unreasonable or arbitrary and are justified if their object is to provide proper medical care to surgical patients.[27]

We conclude that the defendants entered into the exclusive contract with Roux and Associates in order to provide its patients with quality anesthesia services and therefore the requirements of substantive due process have been met.

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[24] *Woodbury* v. *McKinnon*, 447 F.2d 839 (CA5–1971).

[25] *Shaw* v. *The Hospital Authority of Cobb County*, 507 F.2d 625 (CA5–1975), affirmed on rehearing, 614 F.2d 946 (CA5–1980).

[26] *Sosa* v. *Board of Managers of Val Verde Memorial Hospital*, 437 F.2d 173 (CA5–1971).

[27] *Capili* v. *Shott*, 487 F.Supp. 710 (S.D. West Va.1978), affirmed 620 F.2d 438 (CA4–1979); *Sam's* v. *Ohio Valley General Hospital*, 413 F.2d 826 (CA4–1969); *Adler* v. *Montefiore Hospital Association*, 453 Pa. 60, 311 A.2d 634 (1973) cert. denied, 414 U.S. 1131, 94 S.Ct. 870, 38 L.Ed.2d 755 (1974); *Cobb Cty., etc.* v. *Prince*, 242 Ga. 139, 249 S.E.2d 581 (1978) also see cases cited at n.17, *supra*.

VII.

The requirements of procedural due process apply only to the deprivation of interests encompassed by the Fourteenth Amendment's protection of liberty and property. When protected interests are implicated, the right to some type of hearing is paramount. But the range of interests protected by procedural due process is not infinite.[28] The Fourteenth Amendment's protection of property is intended to secure the interests that a person has already acquired in specific benefits. For a person to have a property interest in a benefit, he clearly must have more than an abstract need or desire for it. He must have a legitimate claim of entitlement to it.[29] Relying on this principle, one court has held that a physician had no right to a due process hearing prior to the hospital denying him the right to use certain hospital facilities and equipment, finding that he had no more than a unilateral expectation to use them.[30]

The rationale behind providing a physician with the right to a hearing if he has been rejected for medical staff privileges is to give the applicant a chance to explain matters which might have lead the Board to reject him.[31] He is entitled to a hearing to clear his reputation where some stigma is being imposed on him by the state which may prevent him from taking advantage of future

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[28] *Perry* v. *Sindermanm*, 408 U.S. 593, 92 S.Ct. 2694, 33 L.Ed.2d 570 (1972).

[29] *Board of Regents* v. *Roth*, 408 U.S. 564, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972).

[30] *Adler* v. *Montefiore Hospital Ass'n of W. Pa.*, 453 Pa. 60, 311 A.2d 634 (1973).

[31] *Battle v. Jefferson Davis Mem. Hospital*, 451 F.Supp. 1015 (S.D.Miss. 1976).

employment opportunities.[32] However, where an applicant's rejection has no connexity with his qualifications but rather is based on the state's desire to continue a particular system or operational regulation, his property rights are not infringed upon and he has no right to a hearing.[33]

We conclude that Dr. Hyde was not denied a property right to which he was legally entitled. It is also relevant to the Court that Dr. Hyde's qualifications were not the basis for the denial of the privileges. The Board was merely acting in conformity with its policy to have a closed system anesthesiology department. Dr. Hyde's reputation and qualifications were not at issue and therefore the underlying rationale for holding a hearing was not present. Accordingly, we conclude that plaintiff was not entitled to such a hearing under the circumstances.

VII.

Defendant Jefferson Parish Hospital District was created by the Parish of Jefferson pursuant to Chapter 10 of Title 46 of the Louisiana Revised Statutes and, accordingly, the defendants are governed by the provisions of that chapter in operating the hospital.[34] Pursuant to those provisions "the Commission (the Board of Directors) shall appoint a medical staff. Such appointments shall be made upon the recommendations of the

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[32] *Williams* v. *Barry*, 490 F.Supp. 941 (D.C. Dist. of Col.) (1980).

[33] *Cook County College Techrs. Union Local 1600* v. *Taylor*, 432 F.Supp. 270 (N.D.Ill.1977); *Manion* v. *Kreml*, 264 N.E.2d 842 (Ill.App. 1970).

[34] La.R.S. 46:1051 et seq.

physicians who are authorized to practice in the hospital."[35] Plaintiff relies on the case of *Giles* v. *Breaux*[36] to support his argument that this provision imposes a mandatory duty on the Board of Directors to appoint physicians upon the recommendation of the medical staff.

Giles, an intermediate appellate court decision, involved an interpretation of Act No. 129 of 1950, containing the same language as the above cited provision, which was applicable to the St. Tammany Parish Hospital District. The case involved the revocation of staff privileges of a physician and the Court stated that, in its opinion, the language placed on the Commission the mandatory obligation to appoint any physician recommended for staff privileges by the medical staff.

This Court does not feel bound by *Giles* because it involved an interpretation of a different provision of law. We also find that the *Giles* court did not give a reasonable interpretation to the language contained in the provision.

The Jefferson Parish Council, by ordinance, has made the Board of Directors ultimately responsible for the administration and operation of East Jefferson Hospital.[37] The provisions of the hospital's by-laws[38] and the

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[35] La.R.S. 46:1058.

[36] *Giles* v. *Breaux*, 160 So.2d 608 (La.App. 1 Cir. 1964).

[37] See plaintiff's exhibit 2, By-laws of East Jefferson General Hospital.

[38] Article VI, Section 1 of the East Jefferson By-laws provides upon recommendation by the Credentials Committee and the Executive Committee of the Medical Staff, the Board approves membership on the Medical Staff.

by-laws of the medical staff [39] provide for the Board making the ultimate determination with regard to the appointment of physicians to the medical staff after the Credentials and Medical Executive Committee have reviewed their qualifications and made a recommendation. We interpret La.R.S. 46:1058 to provide that the Board could not appoint a physician who has not received a favorable recommendation from the medical staff. It does not require the Board to appoint every physician receiving a favorable recommendation. Our interpretation gives the language used in the above provision its common and ordinary meaning in accordance with the rules of statutory construction.[40]

IX.

We hold that the hospital was not involved in the diagnosis or treatment of patients and was not illegally engaging in the unauthorized practice of medicine.[41]

X.

For the foregoing reasons, let judgment be entered in favor of defendants, Jefferson Parish Hospital District No. 2 and East Jefferson Hospital Board and against plaintiff, Dr. Edwin G. Hyde, dismissing plaintiff's suit at his cost.

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[39] Article III, Section 3 of the Medical Staff By-laws provide in part: Initial appointments ... to the Medical Staff shall be made by the governing body. The governing body shall act on appointments ... only after there has been a recommendation from the medical staff as provided in the by-laws.

[40] La.R.S. 1:3 and 1:4.

[41] *Rush* v. *City of St. Petersburg*, 205 So.2d 11 (Fla.App. 1967).

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 81-3091

D. C. Docket No. CA 78-750 "F"

DR. EDWIN G. HYDE,
Plaintiff-Appellant,

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and the EAST JEFFERSON HOSPITAL BOARD,
Defendants-Appellees.

Appeal from the United States District Court
for the Eastern District of Louisiana

Before GARZA, POLITZ, and WILLIAMS,
Circuit Judges.

JUDGMENT

This cause came on to be heard on the record on appeal and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed;

IT IS FURTHER ORDERED that defendants-appellees pay to plaintiff-appellant the costs on appeal to be taxed by the Clerk of this Court.

SEPTEMBER 20, 1982